

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/30/2013  
FORM APPROVED  
OMB NO. 0938-0391

|   |  |  |  |  |  |  |                            |
|---|--|--|--|--|--|--|----------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                     |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>155234</b> |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                               |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R-C</b><br><b>10/24/2013</b> |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>WESTRIDGE HEALTH CARE CENTER</b> |  |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>125 W MARGARET AVE</b><br><b>TERRE HAUTE, IN 47802</b> |  |  |                            |
| (X4) ID<br>PREFIX<br>TAG  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   |  |  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE |
| {F 000}   | <p>INITIAL COMMENTS</p> <p>This visit was for a Post Survey Revisit (PSR) to the Investigation of Complaint IN00135822.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00135871.</p> <p>Complaint IN00135822 corrected.</p> <p>This survey cycle began on September 5, 2013.</p> <p>Survey date: October 24, 2013</p> <p>Facility number: 000139<br/>Provider number: 155234<br/>AIM number: 100266410</p> <p>Survey team: Joyce Hofmann, RN</p> <p>Census bed type:<br/>SNF/NF: 60<br/>Total: 60</p> <p>Census payor type:<br/>Medicare: 6<br/>Medicaid: 46<br/>Other: 8<br/>Total: 60</p> <p>Sample: 3</p> <p>Westridge Health Care Center was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to the PSR to Complaint IN00135822.</p> <p>Quality review completed 10/29/2013 by Brenda Marshall Nunan, RN.</p> |  |  | {F 000}  |  |  |                            |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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